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ACC NEWS

President's Page: Image—Seeing Ourselves as Others See Us

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"Image" is a multifaceted concept. Our profession has an image. We as individuals have an image. But each image is truly in the eyes of the beholder and difficult for us even to assess. For example, as cardiologists we may often feel that our profession is under attack. A series of in-depth interviews with ACC members showed that some of us perceive that the public views us as "technocrats." They see high cost procedures; rich, maybe even greedy, physicians, and a profession that has become high tech at the expense of its high touch qualities. At the same time they read in the newspaper or see on television stories about "miracle workers" who save a limb or a life. These stories may lead to bitter disappointment for some patients when their physicians can't perform miracles for them. Still others maintain the traditional image of the physician as dedicated to a noble, caring profession.

A dichotomy is evident in opinion polls, which show that the public holds physicians in low esteem, but loves their individual doctor. The recent American Medical Association public opinion poll (1) noted that 65% of those polled believe most doctors take a genuine interest in their patients, yet almost as many, 63%, believe that doctors do not sufficiently involve patients on treatment decisions.

This complex issue of image became particularly intriguing to me during the College's Health Policy Retreat, held last spring in Washington, D.C. An articulate and impressive young journalist, Nancy Gibbs, a Senior Editor for *Time*, shared with the College leadership her assessment of the public image of physicians, with some unique insights. "More than ever before," she suggested, "physicians are expected to perform miracles . . . but are less appreciated for it." Her hypothesis was that the current tension has developed because of the view of the physician as both magician and salesman-entrepreneur. Complicating the problem is the physician's increasing loss of autonomy and the resulting "emotional moat" between physicians and their patients, further aggravated by a litigious society.

Ms. Gibbs also discussed how the media's selection of stories can reinforce this conflict, particularly because the stories themselves tend either to glorify the miracles of modern medicine or to bemoan the egregious mistakes of a few select physicians. She stressed the need for the medical community to rebuilt its trust with the public (and, I would add, with the media). Listening to her, I was struck by the implications of our image—whichever image it may be. For both the individual cardiovascular specialist and the profession, I believe we have some fence-mending to do.

The image and role of the individual physician. One of my previous President's Pages (2) discussed communication. More than ever I am convinced that as individual physicians we have difficulty seeing ourselves as others see us, hearing how our words and jargon sound, and listening. In the AMA poll cited, 56% of those polled believed that doctors don't care about people as much as they used to, and 71% are frustrated by doctors who keep patients waiting too long in their waiting rooms. So how do we respond as individual physicians? Do we dismiss these comments as those of the public at large—but not of my patients? Or do we reflect for a minute on how satisfied our patients are with us? Is the patient still our primary focus? Do we involve patients as partners in decision-making? If any of us are still under the impression that the "educated patient" is the exception rather than the norm, we need to think again. People want, and indeed argue it is their right, to be involved in their care. They want to understand their condition, consider treatment options, express preferences and make informed choices.

We, as individuals or as a profession, might undertake public relations activities to show the public a caring image. But I think we first have to make sure that reality and the picture of reality that we draw are consistent. Particularly as cardiovascular specialists, we often are involved in high tech procedures and we have to go out of our way to make time for the high touch, caring attitude that our patients seek. We also have to explicitly demonstrate that we neither overuse,

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underuse or misuse our often expensive diagnostic and therapeutic tools and that our ethics are of the highest caliber.

The image and role of the cardiovascular profession. As a profession, cardiovascular specialists should have some concerns if we hear Nancy Gibbs' message and consider various public opinion polls. Collectively the perceived evils of our profession are given more weight because it is generally easier to be more critical of a group than of an individual. It is easier to think "those cardiologists are all more interested in money than patients," than it is to think that of "my Dr. Jones." Nevertheless, as a professional group we need to listen actively to what our public is saying. Public perception *is* the reality.

Aside from the general public, another important public is the managed care industry. The managers within this field have a special perspective on the profession. At the College's recent private sector retreat, I was encouraged to see an openness among managed care professionals and their willingness to establish a constructive dialogue. We learned that managed care organizations are highly interested in the College's expertise and positions, particularly as articulated in documents such as our practice guidelines. However, they perceive our process for developing the guidelines as closed to them. They may view us, collectively, as self-interested. I believe they were pleasantly surprised by our openness in holding a private sector retreat. Similarly, they found our concern for access to cardiovascular care and the impressive Bethesda Conference on this issue as encouraging reflections of responsible concerns and activities on the part of cardiovascular specialists.

I believe that we as a group must demonstrate our interest in societal issues while continuing to focus primarily on patient care. As individuals, we have an opportunity to enhance our professional image by being involved. I know, for instance, that many of our members regularly provide care to indigent patients. A recent survey by the AMA Center for Health Policy Research indicated that two thirds of physicians provide an average of 6.6 hours of charity medical care a week, contributing the equivalent of $6.8 billion a year to needy patients (3). When a caring cardiovascular specialist gives care to those who cannot afford it, the total community benefits, as does the image of the physician. Similarly, all forms of community service reflect favorably on the profession. Involvement in local, state or national health advocacy activities is another kind of effort that is timely and helps to enhance our image.

The role of the College. The ACC statement on mission and goals clearly spells out a role for the College "to increase understanding of the role and contribution of the cardiovascular specialists to high quality health care." We are fortunate that the College does represent the vast majority of cardiovascular professionals and, when the College speaks, it speaks on their behalf. But that implies that the College is involved and actively participating in societal issues as they relate to the delivery of cardiovascular care. We have an obligation, not just to the membership, but to society to use our collective talents and influence to improve the health care of our nation. The College is doing this through its advocacy effort in Washington, D.C., and at the state and local levels through ACC Chapters. Moreover, through Bethesda Conferences, such as the one on access to cardiovascular care, and through our commitment to developing practice guidelines, assessing technologies and building outcome data bases, we are participating in a meaningful way in the issues affecting the profession and our patients. To continue to enhance our efforts, however, we need the full support, involvement and commitment of individual members.

A look into the mirror. We have the opportunity—through individual patient contacts, through participation in our communities and through the College at both the state and national levels—to be major contributors advancing solutions to health care concerns. If we actively and openly communicate with our patients so that we hear and understand how they see us, I believe we will enhance our image. Moreover, if we are open and straightforward about the realities of cardiovascular medicine, and actively address issues of cost-effective care, individual patients and the public as a whole will gain greater understanding and respect for cardiovascular professionals. The College should, as one voice, continue to pursue actively various public outreach campaigns designed to clarify and enhance our image. We must pursue forums that allow for an open exchange of ideas with the public and the chance to "see" each other. The Private Sector Relations Committee proposed plans for the College's first national ACC/Media Forum is a good example of an opportunity to work on that image.

Similarly, we should reach out more to patients and the public by educating them about cost-effective and appropriate cardiovascular procedures, the use of outcome data and practice guidelines and the role of the cardiovascular specialist in the health care system. However, we also need to be confident that we are the best we can be. When we hold up the mirror, we need to be pleased with what we see. And if we are not, let us make a commitment now to work to enhance the reality behind the image.

References

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